The Mentally Disabled Population of the Halifax County Region: Needs and Directions – A Plan for the Future

Report of the Officials Committee
(Community and Social Services)
of Halifax City,
Dartmouth City,
the Town of Bedford,
the County of Halifax,
and the Province of Nova Scotia.

August, 1989

[Halifax: Nova Scotia Department of Community Services]

90-03280/

TABLE OF CONTENTS

1. INTRODUCTION 1

2. METHODOLOGY 1

3. DEFINITION OF MENTAL DISABILITY 5

4. BACKGROUND
   - A. History of Deinstitutionalization 7
   - B. Recent Canadian Trends 9
   - C. Historical Development of Community Services for the Mentally Disabled in the Metro Halifax Area 12
   - D. Survey of Canadian Provinces (Community Services for Mentally Disabled) 16

5. SUMMARY OF COMMUNITY INPUT 21

6. NEEDS ASSESSMENT FINDINGS 22

7. LEVEL OF CARE SURVEY 29

8. OBSERVATIONS & CONCLUSIONS 32

9. STRATEGIES 33

10. SERVICE DELIVERY CHOICES 34

11. RECOMMENDATIONS 35

12. FINANCIAL CONSIDERATIONS 39

13. ACKNOWLEDGEMENTS 42

APPENDICES
- A. TECHNICAL REPORTS
  - i Needs Assessment Survey
  - ii Level of Care Survey
  - iii Vocational Services Report
- B. SUBMISSIONS FROM COMMUNITY AGENCIES

1. INTRODUCTION

There have been numerous studies over the past few years concerning the needs of mentally handicapped and mentally disabled adults. While all have added to the knowledge base, none has concentrated, in a comprehensive manner, on the residential and day program needs of this population in the Halifax County area by documenting the adequacy of current services, suggesting changes to the current service system and making long-term projections aimed at service direction, priorities, and growth requirements.

The Minister of Social Services, the Honorable Edmund L. Morris, in an attempt to move beyond an ad hoc method of responding to requests for service development, wrote to the Mayors of Halifax, Dartmouth, Bedford and to the Warden of Halifax County in June of 1986. He invited them to appoint senior municipal staff to sit on an "Officials Committee", along with Departmental staff, to develop an overall strategy to respond to the projected needs of mentally handicapped and mentally disabled adults in the metropolitan area over the next twenty years. All four municipalities responded, and the Officials Committee held its first meeting in September of 1986.

The Committee quickly realized that in order to approach its task logically and comprehensively that it would have to consider the mentally handicapped and mentally disabled population as entirely separate target populations. Thus, the Committee concentrated its efforts in 1986/87 on requirements for the mentally handicapped, producing an "Interim Report of the Metro Officials Committee on Services for Mentally Handicapped Adults" in June 1987. The report was approved in principle in September 1987 and the key recommendations are currently in the process of implementation.

In June, 1987 the Officials Committee began its deliberations on the needs of the mentally disabled population and the following represents the outcome of the Committee's findings, observations and recommendations.

2. METHODOLOGY

In June, 1987, the Officials Committee determined that five broad areas of consideration needed to be addressed in order to accomplish its mandate. The following outlines these areas and the actions taken:

i A review of the Trends in Mental Health Services in North America, Canada and in Nova Scotia during the past thirty years and current trends in other Canadian jurisdictions to provide some perspective for the study.

ii A Level of Care Survey directed towards mentally disabled individuals residing in licensed facilities and unlicensed residential programs to determine whether or not these individuals were receiving appropriate levels of care and, if not, what levels of care were required.

iii A Needs Assessment Survey involving all mentally disabled individuals residing in licensed facilities and a 20% sampling of identified mentally disabled individuals living on their own or in supervised settings in the community to determine by direct interview this target population's needs in the areas of housing, social interaction, recreation, health services and other related topics.

iv An analysis of day program/vocational future requirements in the area of vocational services in the Metro area through the establishment of a working group mandated to study this particular aspect of need in some depth. The approach of this group was to analyze accumulated data and reports of key observers in the vocational services field.

v A consultation with various Metro area service agencies and advocacy organizations knowledgeable and concerned with the nature and quality of services available for the mentally disabled.

Further details on the methodology utilized in the various studies are included in the appendices of the report.

TARGET POPULATION FOR NEEDS ASSESSMENT SURVEY

The method of this research project was to interview long- term mentally disabled persons who reside in the Metropolitan area: i.e., Halifax, Dartmouth, Bedford and Halifax County.

Prior to this survey, a comprehensive list of long-term mentally disabled persons residing in the Metropolitan area did not exist. In order to select participants for this study, a list of the target population who met the following stated criteria was developed using financial records from the Municipalities of Halifax, Dartmouth, County and Bedford as well as from the Regional Office, Department of Community Services, which administers Family Benefits Program. Persons to be included in the target population:

i were in receipt of Provincial (Family Benefits) and/or Municipal Social Assistance, and

ii resided in the community either by themselves, with family, or in an unlicensed setting; i.e., community residence, supervised apartment or in a Home for Special Care

iii have been diagnosed with mental illness for more than one year

iv have been hospitalized due to their illness for a prolonged period, and

v - - have some functional impairment as a result of their illness.

There were 1,012 persons in the Metropolitan area who met the study criteria. However, it was decided to eliminate those 65 years and older reducing the target population to 936 persons. Of these 138 persons resided in licensed facilities; i.e., ARC, RCF, RRC, and Group Homes and 798 persons resided in the community; i.e., self-care and supervised residences.

Fig. 1 illustrates the characteristics of the target population, research population, and non-participants. The following chart compares each of these groups according to various characteristics:

Figure 1
Characteristics of the Population Studied

TARGET POPULATION	RESEARCH POPULATION	NON-PARTICIPANT POPULATION
Most live alone	Most live in RCF	Most live in RCF
Most between 35-39 years	Most between 35-39 and 60-64 years	Most between 60-64 years
Most live in Halifax	Most live in Halifax	Most live in Halifax
Majority receive Family Benefits	Most receive Municipal Assistance for HSC	Most receive Family Benefits
Majority are single	Majority are single	Majority are single
Diagnosed as psychotic	Diagnosed as psychotic	Diagnosed as psychotic
Most have less than Grade 12	Most have less than Grade 12	Most have less than Grade 12
Majority are male	Majority are male	Majority are female

Of the mentally disabled population most live in Halifax, the majority are single, most are diagnosed as psychotic, and most had less than Grade 12 education.

Primary caregivers were asked to record additional client needs in areas of housing, self-care, employment, and training, recreation, education, social activities, and psychiatric services. This questionnaire was completed for all study participants.

As previously mentioned, the research population was comprised of two groups - those living in licensed care facilities and those living in the community; i.e., self- care/supervised residences. Long-term mentally disabled individuals residing in the community were randomly selected from the target population. They were contacted by letter informing them of their selection to the study and seeking their permission to be included in the research population. They were asked to contact the interviewers to confirm their participation.

All long-term mentally disabled persons residing in institutions who met the study criteria were included as part of the research population. These persons were personally contacted to obtain their consent and to arrange for an interview.

Data were collected on 238 participants from the sample of 336 persons that was selected from the target population (936 persons). The response rate was 70.8%. Ninety-eight individuals refused to be included in the study upon initial contact or were unavailable at the pre-arranged time of their interview. The non-participation rate was 29.2% and the profile on non-participants is illustrated in Figure 2.

Figure 2:
Rates of participation and non-participation for the supervised facilities and community sub groups.

GROUP	PARTICIPATION	NON-PARTICIPATION
Licensed Facilities (n = 140)	104 (74.3%)	36 (25.7%)
Community * (n = 196)	134 (68.4%)	62 (31.6%)
Research Population (n = 336)	238 (70.8%)	98 (29.2%)

(Needs Assessment Survey 1987)

* includes clients in Supervised Residences

The data collected from the Needs Assessment were analyzed using a statistical package (SPSS-PC) for an IBM compatible microcomputer.

The data for this study was analyzed according to the living arrangements of the research population and thus three categories were created according to whether study participants:

i resided in Homes for Special Care - referred to as "Licensed Facilities"

ii received no formal support at their place of residence, referred to as "self-care"

iii had formal support available at their place of residence- referred to as "Supervised Residences"

The next figure shows the demographic characteristics of the research population (238 participants). The demographics presented include: average age, sex, marital status, settlement, income source, diagnosis, and education. Figure 3 is a comparison of these characteristics among the research sample, licensed facilities, self-care, and supervised residences.

Figure 3:

Comparisons of demographis characteristics for research sample and sub groups of licensed facilities, self-care, and supervised residences.

RESEARCH SAMPLE N: 238	LICENSED FACILITIES N:104	SELF-CARE N: 108	SUPERVISED RESIDENCE N:26
Average Age			
43.1 years	48.4 years	42.7 years	41.8 years
Sex			
60% male	64.4% male	56.5% male	57.7% female
Marital Status			
60% single	68.3% single	47% single	80.8% single
Settlement			
50% Halifax	54% Halifax	60% Halifax	42.3% Halifax
33% Dartmouth	28% Dartmouth	19.4% Dartmouth	57.7% Dartmouth
13% County	18% County	10.2% County	
Income Source			
43% HSC	91.1% HSC	58.3% FB	46.2% FB
		10.2% wages	26.9% MSA (Hfx)
			15.4% MSA (Dart)
Diagnosis			
80% psychotic	74% psychotic	84.6% psychotic	84.6% psychotic
Education			
61.4%	53%	70.4%	57.7%
less than G. 12	less than G. 12	less than G. 12	less than G. 12

Vocational Service/Day Program needs were reviewed in two fashions - one by a Vocational Services Sub-Committee which met over several months and provided a detailed review of the population serviced by the community agencies and projected future needs on the basis of their experience and accumulated information.

The agencies represented on the Vocational Services Sub- Committee collectively provided services to a broad range of individuals. This includes persons with schizophrenia, affective disorders, neurotic disorders, personality disorders, those affected by accidental brain damage, and those suffering impairment resulting from drug and/or alcohol abuse.

A second approach to Vocational/Day Program service needs was compiled by the Sub-Committee studying the broader area of needs and services for the mentally disabled through the "Needs Assessment Survey" and the "Level of Care Survey". In these surveys, the mentally disabled were defined as those persons with a functional psychosis only, with a persistent duration (at least one year), and with a disability defined as a disruption in functional capacities (self-care, interpersonal relations, work, etc.), necessitating prolonged care (see definition of Mental Disability on page 5 of this report).

As the target populations differed considerably (as visually described by Figure 13 on page 26, so have the findings, observations and recommendations of the two groups studying this service area.

3. DEFINITION OF "MENTAL DISABILITY"

At least 20% of the population have some form of mental disease, most of which is relatively mild, of short duration and not disabling. Most of the mental disorders in the community are phobias, alcohol and drug abuse disorders, situational reactions or transient anxiety/depression. Very few of these disorders require continuing specialized psychiatric treatment. These kinds of mental illnesses are not usually considered as mental disability. *

A small fraction, less than one percent, of the population have more severe and very disabling mental disorders. Various terms are used- "chronic mentally ill", "long-term mentally ill", "mentally disabled", "severely and persistently mentally ill". These terms refer to persons who have been hospitalized for prolonged periods or who, prior to deinstitutionalization, would have been long-stay mental hospital patients. The mentally disabled are quite diverse in their symptoms, disabilities, strengths, problems, motivations, backgrounds and needs. They share the following characteristics:

i There are marked difficulties with tasks of daily living and recurrent problems in meeting basic survival needs.

ii There is extreme vulnerability to stress.

iii There is lack of either motivation or the ability to seek help.

iv There is a tendency towards episodes of "acting out" behaviours that interfere with the well- being of themselves or others.

*Toews J. and Barnes G.
Chronic Mental Disorders in Canada
Ottawa: Dept. of Health & Welfare, December 1982

Definition of mental disability- **

In this paper mental disability refers to persons who satisfy each of the following three criteria:

i Diagnosis - persons with functional psychoses,

ii Duration - persistent duration (at least one year), and

iii Disability - which disrupts functional capacities (self- care, interpersonal relations, work), and necessitates prolonged care.

**Bachrach, L A.

Defining Chronic Mental Illness: A Concept Paper. Hospital & Community Psychiatry 39: 383-388, 1988

National Institute of Mental Health

Towards a Model Plan for a Comprehensive Community Based Mental Health System

Administrative Document, October, 1987

The severely mentally ill adult population includes individuals 18 and over, regardless of where they live. These persons may be in institutions, community residential settings, with families, in independent apartments, or, in the case of homeless persons, with no fixed place of residence.

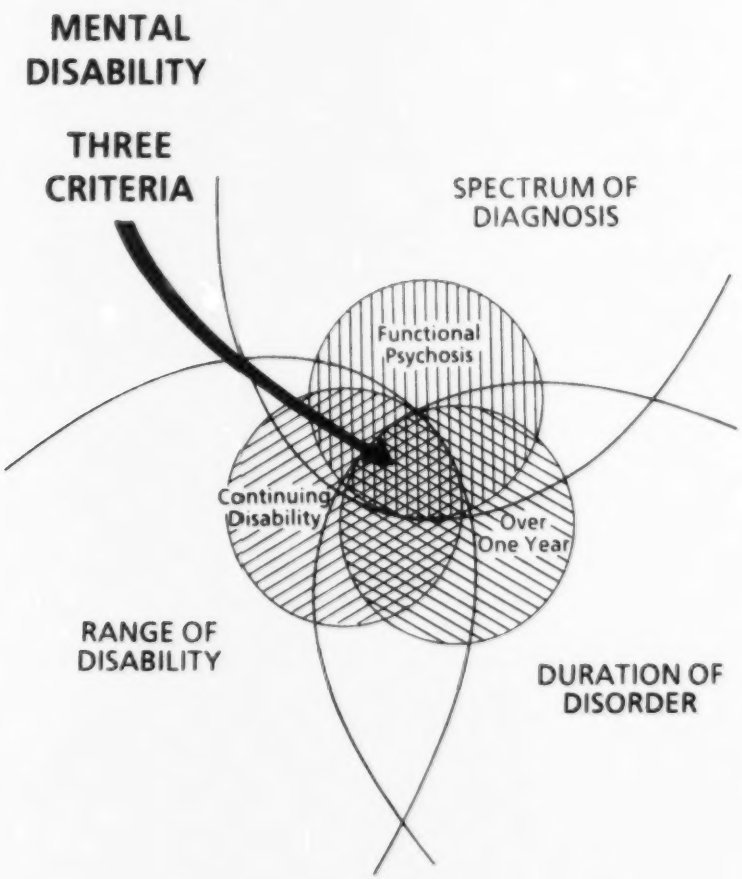
The following figure emphasizes how all three criteria must be met before a person may be designated as mentally disabled. One oval represents persons with some mental disease or diagnosis. A second oval represents various levels of disability and a third oval represents various durations of disability.

Within the diagnosis oval a smaller circle represents persons with functional psychoses (schizophrenia or manic- depressive disorders). Within the duration oval the smaller circle represents durations of disability lasting over one year. Within the disability oval the smaller circle represents severe and profound levels of disability.

The area where the smaller circles overlap represents persons satisfying all three criteria of functional psychosis with severe disability lasting over one year.

It should be noted, however, that although persons within the centre of this figure satisfy all three criteria, this group is heterogeneous. The individuals vary widely in their other characteristics (alcohol and drug use, personality disorders and organic brain disease) and in their needs.

Figure 4:



4. BACKGROUND

A. HISTORY

i Institutionalization 1932-1956

Mental institutions in the 1930's were relatively large and segregated from other health and social services.

In the 1940's the emphasis was still on custody. Treatment and welfare services often worked at cross purposes or were unaware of each other's activities. Upon return to the community, the discharged patient often experienced considerable hardship since his/her vocational and social adjustment had received scant attention before discharge.

Mental hospital directors then emphasized:

- the accumulation of "chronic" patients for whom mental hospital care was no longer essential, but for whom no other resources were available.
- the need to develop alternative resources for the "socially rejected and misfit".
- problems in providing adequate aftercare for discharged patients.

In many of Nova Scotia's county or municipal homes there was a terrifying atmosphere of hopelessness, mixed with Hogarthian bedlam, where patients, male and female, of all types and ages, were penned in day after day, week after week, month after month, endlessly staring at blank walls and ugly surroundings. (Provincial Survey, 1950)

Despite the building of additional mental hospital beds, overcrowding continued. Each year, more patients entered Canadian mental hospitals than left hospital. Discharge rates were low. In the 1940's one-third of first admissions with functional psychoses would stay at least two years. Death rates were high; after one year patients were more likely to leave by dying than by being discharged. By the 1950's one third of admissions stayed at least 4 months. For admissions staying over four months, one third would remain continuously hospitalized for at least ten years.

(Richman, Alex - 1964)

Long-stay cases in the 1950's

"The patients are as clean and neat as is possible to keep them..We treat them well, we take care of all of their needs and they have nothing to worry about. Many of them, especially the old folks, have nowhere else to go, anyway. They realize they're better off here than they would be outside."

(Royal Commission on Health Services - 1964)

In 1956 one-half of all mental hospital patients had been hospitalized for over 7 years. One-third of the 20,000 patients over the age of 60 had been admitted more than 20 years earlier.

ii Dehospitalization 1956-76

Between 1956 and 1976 the psychiatric institutions changed. The hospitals discharged many long-stay patients. Discharge rates improved, lengths of stay shortened and fewer patients became long stay. More patients left than were admitted, the institutions decreased in size.

Figure 5:

Canada, public mental hospitals, (All ages, all lengths of stay)
Patients on books

	NUMBER	RATE PER 1,000 POPULATION
1956	55,848	3.47
1961	58,270	3.19
1966	44,967	2.25
1971	33,520	1.55
1976	22,228	0.97
1977	20,445	0.88
1986	14,949	0.59

(Richman & Riley, 1988)

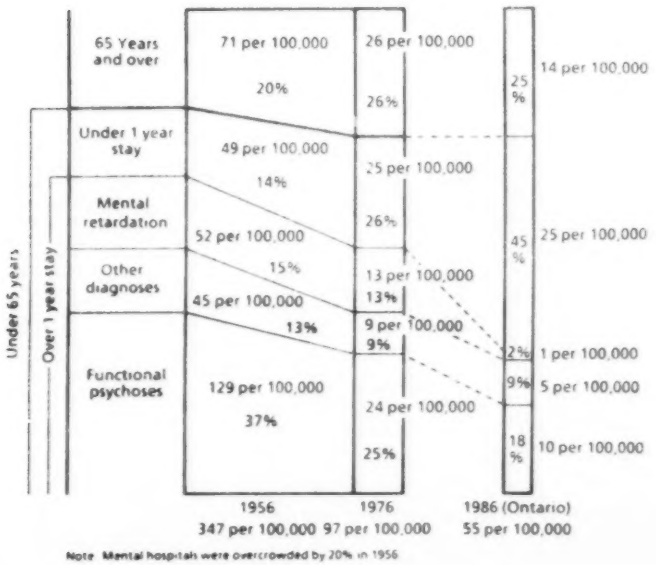
In 1956 there were 196 patients (all ages) with functional psychoses in mental hospitals per 100,000 Canadians. If this ratio were applied to today's population there would still be 49,700 patients with functional psychoses in Canadian mental hospitals (1,700 for Nova Scotia and 590 for metropolitan Halifax).

Between 1956 and 1986 the elderly had decreased by 80%, long-stay patients (over one year) by 92% and the mentally retarded by 98%. Much of this decrease was associated with the shift of departmental responsibility - a governmental response to the 50% federal reimbursement by the Canada Assistance Plan for social assistance expenditures for persons "in need". Responsibility for the mentally handicapped was shifted from the Provincial Dept. of Health first , later many of the mentally disabled were transferred to Homes for Special Care. (Simmons 1982 , p.207)

Between 1976 and 1986 the mental hospital population dropped a further 43% from 97 patients to 55 patients per 100,000 population. The elderly (all lengths of stay) decreased from 71 per 100,000 in 1956 to 26 in 1976 to 14 in 1986. The long-stay population (over one year) and under 65 years old had decreased to 16 patients per 100,000 population.

Figure 6:

MENTAL HOSPITAL PATIENTS ON BOOKS
BY LENGTH OF STAY, DIAGNOSTIC GROUP and AGE
RATE PER 100,000 POPULATION
Canada 1956, 1976; Ontario 1986



Note: Mental hospitals were overcrowded by 20% in 1956

4.B. RECENT CANADIAN TRENDS

i New long stay patients-

We often hear that a new population of long stay patients is accumulating, that we will need more mental hospital beds in the future. Is there evidence for a recent build-up of new long stay cases (between 1 and 6 years) in Canada? There is no evidence of a build-up of new-long stay cases in mental hospitals. In fact, the trend for progressive reduction in long-stay patients is still continuing.

FIGURE 7:

Mental hospital patients, 1-6 years stay, under 65 years
Rate per 100,000 population

	1956	1976	1981	1986
CANADA	226	46	N/A	N/A
SCOTLAND			20	
ONTARIO			12	11
NOVA SCOTIA			27	9
METRO HALIFAX RESIDENTS			22	10

(Richman & Riley, 1988)

ii Current patterns of short-term care (under one year)

Over one-half (55%) of inpatient care is now in general hospital psychiatric units. In 1985 there were 25 general hospital psychiatric unit beds used per 100,000 Canadians, ranging from 15 per 100,000 in Nova Scotia to 35 per 100,000 in PEI.

The use of short-term (under one year stay) mental hospital beds ranges from 32 beds per 100,000 population in Nova Scotia to 6 beds per 100,000 population in Saskatchewan.

Total short-term bed-use (General hospital psychiatric units plus mental hospital use under one year) ranges from 27 beds per 100,000 population in British Columbia to 50 beds per 100,000 population in PEI. Nova Scotia has the second highest ratio with 47 beds per 100,000. Ontario counties show wide regional variations from 31 to 68 beds per 100,000.

FIGURE 8:

Psychiatric bed use in Canada (under one year stay)
Beds per 100,000 population

	MENTAL HOSPITALS	GENERAL HOSPITAL ALL PSYCHIATRIC UNITS	
Province	1983/1986 (A)	1984/85 (B)	(A + B)
PEI	15	35	50
NS	32	15	47
ONT	23	20	43
QUE	16	26	42
NF	16	19	35
ALTA	15	18	33
SASKN	6	24	30
BC	7	20	27

(Richman & Riley, 1988)

iii Long-term mental hospital care:

Despite marked reductions in the number of patients in mental hospitals, many mental hospital patients still remain who could be cared for in community settings. The Harnois Committee (Quebec) 1987 report concluded that the size of the large Quebec psychiatric institutions could be further reduced by more than one half. In Ontario in 1986 there was a two fold variation in long stay cases among the counties, ranging from under 10 per 100,000 population in Peel, Niagara and Waterloo counties, to 11 in Metro Toronto, to 20 in Hamilton and Middlesex counties.

iv Dehospitalization in Nova Scotia

In the last 40 years there have been massive changes in the number of Nova Scotia mental hospital patients from 3,085 in 1962 to 1,347 in 1974 to 438 in 1986.

The passage of the 1966 Municipal Mental Health Act reduced the municipal hospital population by 60%. Of the 1,200 patients transferred from the Municipal asylums, 500 were admitted to boarding homes of about 4-20 residents each, or to foster homes; 700 were housed in the newly designated Adult Residential Centers then called Homes for the Disabled.

The 1976 Simms Committee on Program Rearrangements concluded that 50% of the population in the five remaining mental hospitals had no reason to be in a mental hospital as such. Over 600 mental hospital patients were deemed suitable for residential facilities.

Psychiatric bed use has decreased since 1976/77 when Nova Scotia had the highest rates of short-term bed use (mental hospitals plus general hospital units) in the country. Now, Nova Scotia is second highest in Canada, next to PEI, with a Nova Scotia rate of 47 beds per 100,000 (national average is 35 beds).

In 1976 Metropolitan Halifax had the highest rates of short- term bed use among Canadian metropolitan areas. In the past 10 years the region has decreased its bed use from 73 to 55 beds per 100,000 population, age 15 to 64 (1986).

v Social assistance recipients with mental illness

In the past five years the total number of provincial Family Benefits clients in Nova Scotia has increased about 10%, the "non-psychotic" mental disorders increased 22% from 878 in 1984 to 1,230 in 1988. On the other hand, the number of Family Benefits recipients with functional psychoses (1743 in 1984, 1786 in 1988) or with mental retardation (3547 in 1984, 3716 in 1988) has remained very stable.

In Halifax city there have been 25-30% increases in the number of persons with mental disabilities who are either short- term (53 in 1984 to 61 in 1988) or long-term (129 in 1984 to 170 in 1988) recipients of general assistance.

Over the period 1974 to 1987 the rate of utilization of the Halifax County Regional Rehabilitation Center (General Service Unit) and the Adult Residential Center (Beaverbank, Nova Scotia) has declined significantly. In the case of Halifax City the decline has been in excess of 50% [N = 149(1974); N = 71(1987)]

vi. Estimates of the number of mentally disabled

- [] The Sherbrooke Que Continuing Care program for functional psychoses has admitted 524 individuals from a population of 250,000 over a period of five years- a cumulative rate of 210 per 100,000 population.
- [] Dane County (Wisconsin) (population 325,000) has 1,002 individuals with "chronic mental illness" (308/100,000); one- third of these individuals (113/100,000) received community support services during a one year period.
- [] Metro Halifax (pop. est. 300,000) - During the four years 1982-1985, there were about 250 individual residents from metro Halifax (with functional psychoses) who were admitted and spent over three months in mental hospitals (84 per 100,000 pop). 101 were from Halifax city, 95 from Dartmouth city, 50 from Halifax municipality and 3 from Bedford.

The number of Metro Halifax patients in mental hospitals has decreased in recent years. Between 1976 and 1986, the number of patients in hospital under one year (at March 31) decreased from 199 to 103. There was a 50% decrease for cases hospitalized between 1 and 6 years from 60 cases in 1976 to 30 cases in 1986.

Figure 9:
Patients on mental hospital books, 31 March 1976 and 1986
All diagnoses, 15-64 years

	Dartmouth	Halifax City	Hfx County, (incl Bedford)
Under 1 year stay			
1976	57	86	56
1986	53	31*	19
* excludes patients from Halifax city peninsula in Camp Hill Hospital			
1- 5.9 years stay			
1976	20	20	20
1986	12	11	7

(Richman A., 1988)

Halifax City residents treated with functional psychoses in public facilities:

During a 45 month period there were about 1,800 individuals (under 65 years) with functional psychoses (of any duration or disability) who were treated in mental hospitals, general hospitals or public psychiatric clinics in Nova Scotia. This total represents 1.8% of the total population and includes all severities, durations of disorder and a very wide range of disability.

Figure 10:
Metro Halifax residents with mental disability:

The best estimate of mental disability (under age 65) in metro Halifax is about 5 per 1,000 population or a total of 1500 individuals in the Metropolitan area (fitting the characteristics of long - term or severely mentally disabled).

Mental hospital, over one year stay	0.2 per 1,000
Provincial and municipal social assistance	3.2 per 1,000
Canada Pension Plan, DVA, Long Term Disability private insurance, family support	1.6 per 1,000
TOTAL	**5.0 per 1,000**

(Richman A., 1988)

4. C. HISTORY of the DEVELOPMENT of COMMUNITY SERVICES FOR THE MENTALLY DISABLED IN THE METRO HALIFAX AREA

(i) RESIDENTIAL SERVICES

From the early nineteenth century, paupers were confined to the Work House. The Work Houses became the asylums as more and more of its residents were mentally disabled and mentally handicapped people for whom educational and employment opportunities were virtually non-existent.

In the mid 1950's these asylums had become the municipal mental hospitals and the advent of drug therapy for chronic disorders was slowing the admission rate. By the early sixties, the trend was developing to remove people from these hospitals to less structured settings, although institutional, because of the success of drug therapy.

Community values were also in the process of change as people with mental and physical handicaps were viewed more from the perspective of their potential development and the need to reduce health care costs. In the mid-60's, the Canada Assistance Plan along with the Social Assistance Act Part II, came into law. These laws assured a 50% federal cost sharing in services/assistance to persons in need. These Acts encouraged the transfer of greater responsibility for the care of the long term ill and elderly away from Health and into Social Services.

In regards to the Social Service response to the need of the mentally disabled, the initial thrust was in two areas

(a) the development of Homes for Disabled (now called Adult Residential Centers) and

(b) the Community Residence Program.

With the movement out of the municipal mental hospitals, the tri-level cost sharing on assistance for these people and chemical therapy, the Homes for the Disabled grew at a phenomenal rate. Scotia Nursing Homes, which was the Home for Disabled in this area, had 249 beds with a very low vacancy rate until the late 1970's.

In Halifax City and some other areas of the province, the Community Residence program also developed. In Halifax in 1971, there were 75 clients in the Community Residence program. This program declined after this until the early 1980's. This reduction resulted primarily from staff not being allocated to the program so that the "foster parents" did not receive the support necessary for their tasks.

In the early 1970's, in part as the result of the Simms Commission, there was an increase in the pace of referrals to the Social Services Programs from the hospital services.

In addition, Canada Mortgage and Housing Corporation was providing significant mortgage interest subsidy for municipal and non profit groups who provided residential services.

In the early 1970's, the Halifax Branch of CAMR had opened its first group home in Halifax. Small, homier type environments were seen as more acceptable than the large institutions as the normalization philosophy spread throughout North America. The Dartmouth Branch of the Canadian Mental Health Association in 1974 proposed and eventually developed the first group home in Dartmouth for younger mentally disabled persons. At the same time, pressure was mounting on the municipalities to place people being discharged from hospital, while the A.R.C. facility was operating at 100% occupancy with virtually no movement out. Group homes took minimally 18 months to establish and the municipal mental hospitals were in the process of developing an active treatment model with the resulting increase in discharges of their long term stay patients. Essentially the system of residential services for the mentally disabled was plugged - little movement out, much higher demand for services.

As a result of legislative changes to the Hospitals Act in the later 1970's, and, because of the growing tendency not to admit psychiatric patients to hospital, but treat them through out- patients, as well as a growing awareness of the "inadequacies" of institutional care, pressure was mounting for alternative residential options that would provide support in a more normal situation.

In the latter part of the 1970's significant shifts in the delivery of residential services to the mentally disabled occurred. Some of these included.

(a) The municipal mental hospital role was shifted to active treatment from long-stay with the resulting conversion of long-term psychiatric beds to rehabilitation beds (e.g., Halifax County Hospital to Regional Rehabilitation Center).

(b) Smaller licensed facilities grew in numbers. This is evidenced by the increased number of beds in Residential Care Facilities and Group Homes. The former emphasized maintenance, the latter social rehabilitation

(c) The Supervised Apartment program expanded significantly and became an entrenched part of the system of services for mentally disabled persons.

(d) A growing emphasis on the need of mentally disabled people to be involved in purposeful activity (Project 50, sheltered workshop settings, supported employment).

The numbers of people who are chronically mentally disabled decreased in the hospital system and the large social service institutions. The growth in group homes, residential care facilities, supervised apartments, and community residences not only picked up the numbers from institutions, but also those who would otherwise have required institutional care. This indicated that these options were becoming more and more the first choice of both the client and the service system.

By the early 1980's the smaller residential options (e.g. group homes, supervised apartments) had:

(a) emphasized the client use of generic services

(b) provided contuining support to the client initiative in utilization of services

(c) illustrated the cost effectiveness (e.g. "normal living" with supports on average 1/10 of hospital care, 1/4 of R.R.C. care, and about 1/2 of A.R.C. care)

(ii) Vocational Services:

Historically, mental health policies and services have not placed sufficient emphasis on serving the vocational needs of mentally disabled persons. In Nova Scotia, beginning with The Report of the Royal Commission on Mental Deficiency (1927), much of the discussion regarding "mental illness" has primarily focused on the standards for and adequacy of treatment facilities (Report on County Homes and Hospitals of Nova Scotia, 1948) as well as, on the development of a hospital administered, integrated, mental health services system (Surveys of Hospitals in Nova Scotia 1948 - 50). The importance and impact of these earlier efforts was to not only recognize and address the deficiencies of a County and Municipal based institutional system, but to also begin a push toward creating comprehensive regional mental health systems which were more appropriate for and accessible to persons with mental disabilities. In many respects, this admirable goal to ensure a basic regional psychiatric treatment and intervention system is still seeking fulfillment.

Throughout the 1950's - 60's, with the advent of improved medication, greater awareness, and attractive cost-sharing arrangements, a concerted effort was made toward deinstitutionalization and the repatriation of mentally disabled persons to the community. In 1972, the Brief on Psychiatric Community Mental Health Services outlined a progressive plan to provide a community mental health program with reasonable access to all citizens. The "Townsend Report" emphasized a partnership model with program/service development being based essentially on the needs of each community. This brief set out, as the primary objective, a comprehensive community mental health program to establish provision of services in the order of out-patient and community services, partial hospitalization and full hospitalization. This emphasis on the "community" as the locus of care and rehabilitation was also supported by the Nova Scotia Council of Health (1972) and reiterated in the Guidelines for the Planning and Development of Psychiatric Mental Health Services in Nova Scotia (1983). This latter document reinforced the need to assist persons with mental disabilities "to live at their maximum potential within the community in human dignity and maximum independence."

Essentially, this "policy statement" encouraged a service approach to mentally disabled persons based on principles of independence and maximized potential, community living, as well as integrated planning and agency co-ordinated service infrastructure based on the individual needs of mentally disabled persons. This policy for mentally disabled persons has not met with the same success as with other disability groups.

Three basic approaches to vocational services have developed (Employment Opportunities for People Labelled as Psychiatrically Disabled, a Discussion Paper, prepared by Canadian Mental Health Association National Office, Toronto; April, 1984) across Canada and are evident in developments over the past two decades in Nova Scotia.

a) The Pro-Work Alternative

Work is essential for people with psychiatric disabilities:

- in order for them to earn a living so as not to be dependent upon the state, with consequent feelings of powerlessness and lack of productivity,
- for the satisfaction of successfully completing a task, regardless of the nature of the work (job satisfaction),
- as a creative experience,
- as a therapeutic experience in focusing on the external world,
- as a response to societal expectations and values,
- as a normalizing experience,
- in order to fight the effects of stigmatization,
- as evidence of their recovery from or coping with their disability,
- for self-respect, and
- to form social ties to the community.

b) The Avocational Alternative

This refers to activities freely participated in for diversion, relaxation and personal development. This position arises as a response to three situations:

- increased automation in the workplace especially computer technology, with consequent redefinition of the meaning of work generally,
- high rates of unemployment in the society generally, and
- the nature of psychiatric disability whereby the stress of work may pose a threat to the individual's mental health.

c) The Intermediate Alternative

The alternative between full time employment and the avocational alternative. This recognizes the flexibility required to meet the differing needs of the population, is more inclined to respect their choices, demands a continued supportive involvement of service providers to enable clients to relate effectively with their particular state at any given point.

Services geared to move the client to full-time employment tend to accept those who are the most job ready and suffer only minimal effects of the acute stage of their illness. Consistent reporting from other services indicates that previous work history and the level of social functioning are the most significant factors in predicting employment success for the mentally disabled, put in other terms, prior work history and occupational stability are the best indicators of vocational adjustment.

A person with a reasonably good work history is the most likely to benefit from vocational rehabilitation which is time limited for participation. This is the case in spite of acute episodes of mental illness and some consequent residual effects.

The Jarvis Committee (Report of the Committee to Determine the Needs of the Long-Term Mentally Disabled Person, N.S. Division, Canadian Mental Health Association, May 1985) raised the question, "... that if only a small percentage of long-term mentally disabled persons are able to obtain and keep employment, is it realistic to put a high priority on programs to train people to enter the competitive work force?"

These three approaches apply not only to vocational services but to the full range of residential, social, etc, recreational programs for the mentally disabled.

(iii) Social/Recreational Services

Leisure services for disabled persons were traditionally planned and provided as segregated services for specific groups. These services were intended to serve as diversional activities and were rarely viewed as an essential component of the lifestyle of individual disabled persons. A majority of the traditional social and leisure programs for mentally disabled persons have been and still are operated by local branches of the Canadian Mental Health Association across Canada, with varying degrees of support provided by municipal recreation departments.

Since the early 1970's, there has been an increase in efforts to involve disabled persons in generic leisure services, but a common response at the community level continues to be the development of segregated services, mostly operated by recreation authorities. Efforts by the Canadian Parks and Recreation Association have been made to encourage municipal recreation departments to include planning for needs of disabled persons in their programs, to re-educate recreation personnel about the principles of normalization and integration, to develop opportunities for disabled people to participate at the highest level possible and to provide resources within programs and facilities to ensure integration of disabled persons.

Municipal recreation authorities have responded in a variety of ways, by providing services like leadership development and grants to voluntary associations like CMHA, by cooperating with groups like CMHA to co-sponsor programs and services to the mentally disabled, and by accepting the responsibility for providing the support needed to include mentally disabled persons in programs offered to the community at large. Municipal recreation authorities that have responded with comprehensive services and policies for mentally disabled persons include Thunder Bay, Ontario and Dartmouth, Nova Scotia. All of the 35 CMHA local branches in Ontario have a recreation component to their program.

According to Hutchinson and Lord (1979) the generally accepted principle for provision of service at the municipal level is to ensure that persons with mental disabilities have the opportunity to participate in social or recreational activities, that are appropriate to the level of functioning of the individual. To ensure opportunities are available for all, there needs to be put in place a continuum of services and experiences, ranging from what is best provided in the highly supervised setting of an institution, to that which is available on an integrative basis.

(See Hutchinson, P. & Lord, J. (1979) Recreation Integration.

4. D. SURVEY OF CANADIAN PROVINCES -- An overview

This section is a summary of a more detailed review of social support programs for the mentally disabled in other Canadian provinces. The review is based on telephone interviews with eight provinces, review of written materials from Alberta, Quebec and discussions with the National office of CMHA and some of the provincial divisions.

In 1977 the Canadian Council on Social Development surveyed provincial social services for the handicapped. Hepworth concluded that there was little evidence of a sustained commitment by any provincial government to the support and care of the mentally ill in the community.

> "The personal social services that do exist are either grossly understaffed or often operated on a hand- to- mouth basis with short-term demonstration or project funding.."(p.189)

Twelve years later there is a general feeling that despite improved personal services much more remains to be done.

> There was no evidence of systematic surveys of the concerns of the mentally disabled in the community.
>
> Although there are individual social support services and programs in many parts of Canada there were very few comprehensive community-based programs for social support.
>
> The personal social support programs that do exist are often ad hoc responses to crisis situations.
>
> There are still very few Canadian social support programs for the mentally disabled in the community.

Thirty years ago both the mentally disabled and the mentally handicapped were largely in long-term institutions. Within those thirty years both groups have left the long-term mental hospitals. For the mentally handicapped, social, vocational, recreational and housing programs are now far better developed and more uniformly available across the country. In contrast, support services for the mentally disabled are less developed and less uniformly available.

GENERAL OBSERVATIONS:

Across Canada there is no one direction or pattern of community services. There is some evidence of province-wide efforts to make major changes.

The recent BC Consultative Planning process emphasized that Mental Health Services should be optimally provided to maximize the independence of the mentally ill within the main-stream of community life. At the same time planning should ensure that all resources currently applied to mental health care are maintained, but more efficiently applied to provide a more effective continuum of services. This strategy of resource reallocation shifts some resources from the continuing psychiatric facility part of the mental health system to the community residential area. While maintaining quality and level of care, funds would become available to increase the number of community beds, add rehabilitation programs and provide mental health care to patients outside institutions and closer to their homes.

A second province has a draft four step plan to shift hospital resources to community based programs. The plan proposes:

i Building a Home for Special Care, which can be used for a group of elderly persons now in mental hospital. The Home for Special Care would be located in a population center;

ii Transferring suitable long-term patients from the mental hospital to the Home for Special Care;

iii Providing a level of staffing appropriate for Homes for Special Care in the new Home for Special Care;

iv Shifting the difference between the mental hospital staff years and the Home for Special Care staff years to the general hospital psychiatric program.

Inter-agency cooperation is essential.

Problems of coordination, integration and continuity are not necessarily reduced in those provinces which have integrated their health and social services into one Department.

In BC, as in Ontario, the Ministry of Health emphasized that the Mental Health Services Division should continue to take the lead role in improving the integration, co-ordination and accountability concerning all services for the mentally ill between Ministries of the Provincial Government, Divisions of the Ministry of Health, and various government and non-government programs and services at all levels.

Ontario is currently developing inter-Ministry guidelines for clarifying the responsibilities and jurisdictions of the Ministries of Health, Community and Social Services, and Housing.

Some provinces recognize the advantages of making generic services (existing programs for the general population) more accessible to the mentally disabled, rather than developing new, segregated, specialized services. Services must be available as part of ordinary life. Education, employment, social and leisure opportunities are as important as specialized health and social services. The BC 1987 Plan recommended that wherever possible, support should be given to help community services to be active partners with the more formal mental health services in caring for the mentally ill.

Participation by mentally ill persons in social programs provided through general community services should be encouraged wherever possible as an opportunity for social integration and normalization.

Consumers of services must be treated as equal partners with the providers.

The clients themselves and their relatives need to be actively involved in the community support program -- both in forming their treatment and rehabilitation plans and in advocating for the community's support program within the larger society.

"There should be nothing token about consumer participation...it means playing an active part in decisionmaking and not merely being relegated to some indirect, unspecified advisory role"

Hon. Jake Epp 1988
(Minister, Health and Welfare Canada)

There is increasing recognition that caregivers need support.

"Caregivers need to be assured that they will not be expected to shoulder limitless burdens."

Hon. Jake Epp 1988
(Minister, Health and Welfare Canada)

Existing Services should be monitored and evaluated.

The following questions are suggested by one province -

i How many persons with long-term psychiatric disorders are currently engaged in rehabilitation and support?

ii How many persons have an assigned primary case worker or manager?

iii How many persons have individual program plans? (drafted with the person and his/her family or other caregiver involved)?

iv How often are case conferences or planning meetings held on each individual?

v How often are home visits made?

Hard-to-manage-clients -

A small number of clients who are extremely difficult, presently use a disproportionate amount of services. Plans need to be made for the continuing management, rather than the ad hoc treatment, of these individuals.

RESIDENTIAL:

Housing is regarded as a priority in all provinces.

A variety of housing programs are needed with a spectrum of services ranging from:

Transitional, interim time-limited post-discharge programs to long term continued-stay programs.

Full-time around the clock supervision to unsupervised settings.

Programs with built-in social and recreational programs to programs providing housing only.

Some provinces are providing funds for CMHA and other community groups to develop housing programs. There is a general belief in the value of community-based boards to operate these housing programs.

Boarding homes persist, particularly in rural areas, and seem to provide a kind of service which is still essential.

Crisis housing. The Greater Vancouver Mental Health Service (population 510,000) operates a 10 bed Emergency residence for short term assessment and stabilization of clients who are in social crisis. This service provides after-hours telephone answering service for the community mental health teams.

Housing programs with higher levels of staffing are not necessarily better able to deal with disturbed behaviour.

Indeed, the converse is true in metropolitan Toronto where programs with higher levels of staffing are taking less disturbed cases than programs with lower levels of staffing. A recent survey showed that 75-80% of current discharges from Queen Street Mental Health Center would not be eligible for placement in residences with the highest level of staffing.

"Clearly, the admission criteria of group homes designed for the long-term mentally ill specifically exclude a great proportion of the population. Given the recent group home funding trend, these findings are of great concern as they indicate that group homes for the long term mentally ill are currently rejecting the very individuals they are mandated to serve.

(John Trainor et al,
Queen Street Mental Health Center, 1987)

The BC plan recommends that the current per diem funding method based on the "level of care" system should be reviewed with a view to developing a means of funding residential facilities to provide specific programs for specific client types.

Assessment units are transitional facilities accommodating 8-11 residents. Community mental health staff conduct comprehensive assessment of clients' functioning during short term stays in order to determine suitable residential placements. Alberta has 19 slots in such programs costing $233,000. per year.

MEDICAL PSYCHIATRIC:

Where psychiatric service data exist, the mentally disabled do not use a predominant share of out-patient care. A minority of the mentally disabled, who use a disproportionately high amount of services (hard-to-treat group), need increased attention. In Nova Scotia less than one-third of all outpatient clinic staff time is spent with functional psychoses.

Richman A, 1989

There are very few Canadian programs targeted for the mentally disabled. Greater Vancouver and Sherbrooke, Quebec have such targeted programs.

Mental Health Emergency Service. The Greater Vancouver Mental Health Service assists mentally ill clients in the community who require prompt intervention in a mental health emergency. It works closely with the hospital emergency departments and the Police.

The Emergency Service, located at the Emergency Service of the Ministry of Social Services and Housing, is staffed daily from 17:30 to 3:30 by one community mental health nurse with specialized training and experience. The Emergency service is backed up by an on-call physician. During 1982 there were 3,432 service calls; 89% were handled by phone; 376 calls required face-to-face interview, 90 of which involved a psychiatrist. Most of the callers (89%) were previously known to the Service.

Sherbrooke, Quebec program for the mentally disabled.

Dr. Francisco Pinero of the Hotel Dieu de Sherbrooke has described the Sherbrooke program in detail. Sherbrooke is a city of 100,000 with a total catchment population of 250,000. The region has no mental hospital, only general hospital psychiatric units. Very few Sherbrooke residents are now treated in mental hospitals outside the region.

Beginning in 1973 Sherbrooke residents who were long-stay patients in mental hospitals outside the region were repatriated to Sherbrooke. About 600 of these patients had been hospitalized for over 10 years. A Continuing Care program, established in 1976, was unified at one hospital (CH Hotel-Dieu de Sherbrooke, R Carle MD, Head, Dept. of Psychiatry) in November 1981. This program is focused on patients with functional psychoses who have been ill for at least two years. The general hospital-based program has 40 inpatient beds, 15 slots in a day hospital, 6 slots in a night hospital and 45 places in a occupational therapy program. As well the program has a Walk-in clinic, an injection clinic, a Lithium clinic, a follow-up clinic, various therapeutic groups.

In addition there are extramural services for psychiatric rehabilitation (20 places) and a live-in rehabilitation program for 25 cases. The social services provide supervised apartments and foster families. There are also a number of religious and lay voluntary programs.

A total of 524 individuals have been admitted to the program over 62 months. 53 referrals were not considered appropriate for the program. The number of referrals per year has been steadily declining from 176 in the first full year of operation in 1982 to 69 in 1985 to 33 in 1986. To the end of 1986 this would represent a cumulative rate of 524/250,000 = 219 per 100,000 population.

Hospital lengths of stay have declined progressively. Sherbrooke's mentally disabled use less than 16 bed per 1,000 total population. Two-thirds (64.5%) of the enrolment were hospitalized at least once during the 62 month period. Two-fifths (41%) of those hospitalized had only one hospitalization.

Home visits- Staff made home visits to over two-fifths (44%) of the enrolment in 1986. There were 2,746 home visits to 230 cases, a mean of 12 visits per year per case visited.

Occupational workshop- Thirty percent of the enrolment attended occupational workshops in recent years. The 152 individuals made an average of 57 visits each during the year.

VOCATIONAL / DAY PROGRAMS

There is generally a paucity of information nationally on the range of vocational services/day programs available to mentally disabled persons. This problem is exacerbated by the fact that these services have historically been developed and delivered by separate ministries of Health and Social/Community Services at the provincial level; different departments of the municipal level of governments (Social Services, Recreation, etc.) and a variety of community groups and organizations.

Of the provinces surveyed who responded to the vocational services question, one province has acknowledged that at the basic level, services for the mentally disabled could benefit by avoiding the sheltered workshop phase and move individuals more directly into sheltered work and subsidized employment. In regard to workshop type services, two provinces emphasize "workshop without walls" - the placement of individuals or supervised groups of individuals into regular commercial and industrial settings.

It is generally recognized that to be effective, vocational services for mentally disabled persons must incorporate a broad continuum of services with necessary support services being provided at every stage.

There is unanimity that as a guiding principle mentally disabled persons should be encouraged wherever possible to access generic vocational training and employment services available in the community.

SOCIAL / RECREATIONAL

A survey of other Provinces produced very little information on social or recreational programs. In Toronto, Community Occupational Therapy Associates has developed some program supports for mentally disabled persons in the community.

FEDERAL PERSPECTIVE

Hon. Jake Epp (Minister, Health and Welfare, Canada, 1988) has recently released the discussion document -- Mental Health for Canadians: Striking a balance. The report recognizes the needs of the mentally ill for adequate food, clothing and shelter; for a nurturing, accepting setting that supports personal growth and development, and for opportunities to have meaningful social roles.

The Report advocates ---

Better coordination of the policies, programs and objectives of a multiplicity of agencies and organizations, and at many levels.

Fostering public participation by the mentally disabled in helping shape the policies and systems that affect their lives.

Encouraging involvement in mutual-aid, community development and other grass-roots processes that enable people to work collectively to identify and deal with common concerns.

Supporting and reinforcing the efforts of family care-givers and health professionals by putting in place a broad range of practical and psychosocial resources that they can count on.

Committing a greater share of resources to community development and community-based programs and services.

This section has outlined some of the ways our social services can help attain the principles advocated in the federal document.

5. SUMMARY OF COMMUNITY INPUT

Seven of the nine groups/service delivery organizations who presented briefs to the Officials Committee were present at the hearings held on June 16, 1987. Copies of the written briefs, as submitted, are attached as Appendix B. Consistency of themes prevailed throughout the various presentations. A summary of the common themes follows:

i Day programs are seen as a critical component of support services; therefore, it is necessary to develop day programs which will lead, whenever possible, to increased independence in the living and/or employment situation.

ii A "case management" approach to the needs of each individual be adopted with a designated person providing coordination and continuity for both residential and vocational services. This approach would focus on individual needs as opposed to fitting the individual into existing service categories; as well as assuring timely access to needed assistance.

iii There is an urgent need for the provision of twenty- four-hour crisis assistance for those mentally disabled individuals living in this community. This assistance would be directed toward enabling both the client and involved family and friends to cope with emergencies while maintaining the client's status as a functioning community member to the greatest extent possible.

iv The vital advocacy, social support and self-help functions provided by advocacy groups and self-help groups be encouraged through increased financial support.

v Individuals working with the mentally disabled, whether in a community or institutional setting, be given specialized training in the area of mental health/mental illness necessary to meet the special needs of this population.

vi There is an urgent need for adequate accommodations for the mentally disabled which must be accessible from either the community or the institution and must approximate the size of contemporary family and social living arrangements.

vii There must be a continuum of services which provides the opportunity for the mentally disabled person to access a variety of services of different kinds. Although it is recognized that many of these services are currently available, effective utilization of these services is hampered by fragmentation and lack of coordination.

The need for improved coordination of services thereby reducing fragmentation and duplication of services and allowing for enhancements was the main theme expressed by the groups presenting. The above-noted enhancements were viewed by the various groups as vital in meeting the current deficiencies in obtaining adequate housing, suitable day programming, case management and crisis intervention for the mentally disabled.

6. NEEDS ASSESSMENT FINDINGS

The following questionnaire was administered by the interviewers to the study participants and their primary caregivers (i.e., staff from licensed facilities) and social workers.

Needs assessment questionnaire

The questionnaire was intended to determine demographics, levels of satisfaction, and use of services and programs on a formal and informal basis in the following areas: housing, social activities; employment and training; education; physical health and hygiene; psychiatric services; and recreation (see Appendix). This questionnaire was administered to all study participants (n = 238).

The questionnaire was divided into eleven sections not including the Demographic Section which was described earlier. For the purpose of describing "Findings", these eleven headings were grouped under six major headings:

i Housing,

ii Formal/Informal Social Activities & Recreation,

iii Education/Employment,

iv Hygiene/Nutrition,

v Medical/Psychiatric and

vi General Satisfaction.

The following outlines some of the findings which were most striking to the study committee. The reader may examine each table in depth to gather further detail (See Appendix)

Summary of Findings For Research Sample

When we compare the responses for participants in licensed facilities, self-care, and supervised residences, we find the following:

A. Housing

1. A higher percentage of individuals in licensed facilities, particularly ARC's, had stayed the longest length at current addresses.
2. In looking at the factors on feelings about food, rules, other people in the residence, privacy, freedom and continued residency the following table outlines the percentage of clients who felt positive ("satisfied", "pleased", "delighted").

Figure 11:
Satisfied/Pleased/Delighted responses to satisfaction level for items in Col I

	LICENSED FACILITY GROUP	SELF CARE GROUP	SUPERVISED COMMUNITY LIVING GROUP
Col 1	Col 2	Col 3	Col 4
Food	50%	47%	81%
Rules	56%	N.A.	73%
Other People	46%	70%	69%
Privacy	48%	81%	96%
Freedom	59%	90%	85%
Continued Residency	39%	52%	69%

3. More people in the supervised residences preferred their current living arrangements in terms of with whom they live. They preferred their current residential setting to their previous place. They preferred the "house rules" where they reside.

4. More people in supervised residences felt better about a prolonged stay in their current residential setting.

The Supervised Community Living Group reported positive feelings about their residential situation more frequently than the other two groups.

B. Formal Social Activities, Informal Social Activities and Recreation

This section sought responses to respondents' actual participation with informal social activities (family, friends, other unstructured activities); formal social activities (religious activities, Mental Health Dartmouth, Hope Cottage, Alcoholics Anonymous and other activities which have a formal organizational component) and recreation(meaning formal organized recreational activities).

Telephone and/or mail contact with families by the respondent was weekly or more frequently with 43% of the licensed facility group and 62% with the supervised community living group. (46% of the self care group already lived with family.) In the Licensed Facility Group 27% had not phoned or written to family in the past year while this was the case only with 4% of the supervised community living group.

Family initiation of phone and/or mail contact on a weekly or more frequent basis applied to 30% of the licensed facility group and 35% of the supervised community living group.

In the case of person-to-person contact with family, 26% of licensed facility group and 28% of supervised community living group had a contact weekly or more frequently.

In the licensed facility group, 28% had no contact within the previous year while 4% of the supervised community living group reported having no contact with family in the previous year.

In regard to having friends, 72% of the licensed facility group; 91% of the self care group; and 100% of the supervised community living group reported "yes".

1. Family contact is lowest amongst those living in licensed facilities.

2. Family contact is highest amongst those in supervised residences.

3. Regular contact with individuals described as friends is lowest amongst those in licensed facilities.

4. Regular contact with individuals described as friends is highest in community supervised residential settings.

5. Individuals in community supervised residences are involved in a greater number and variety of informal social activities, closely followed by those in self- care settings.

6. Individuals in self-care situations use a broader array of available formal social activities.

7. Individuals in supervised residences felt most positive about the social supports and activities available to them.

8. The licensed facility group most frequently reported participation in passive activities (watching T.V., listening to radio, walks) while self care clients more frequently reported participation in both passive and active activities. The supervised community living group reported more frequent involvement in active events.

9. Within formal social activities, those of a religious nature were most frequently used by respondents across all three residential type categories. (It may be pointed out that these activities usually are time regular, predictable, integrated, accepting, allowing for a degree of person initiated involvement, and as demanding on the person as they wish it to be.)

C. Education & Employment

The needs assessment survey found that:

1. A higher proportion of those in supervised settings have fewer problems with reading and writing; however, in this setting a higher proportion are attempting to improve their education and feel they have a need for more education.
2. More residents in licensed facilities and supervised residences are involved in sheltered work and Project 50.
3. While 50% of the sample population said they would like to have a job, only 16% are actively looking.
4. While approximately the same proportion of individuals in self-care settings as supervised residences would like a job, almost twice the percentage in supervised residences are actively seeking employment.
5. Approximately 1 in 5 of those in self-care circumstances report that they have some income from employment (Project 50, workshop, part-time work).

In addition to the Needs Survey's identification of employment utilization among the mentally disabled sampled, a Vocational Services Sub-Committee addressed the issue of employment and employment preparation from the service providers perspective.

Those participating in the sub-committee represented:

DartmouthWork Activity (30 people served annually);

Employment Outreach Counselling (140 people served annually);

Haltrans Industries (40 + people served annually);

Lake City Industries (28 people served annually);

Options Work Activity Program (36 people served in 1986/87).

Their approach was to evaluate the current population they provided services to, and to examine the needs of this group, as well as those who had used or/and requested their service.

In their findings the Vocational Services Sub-Committee identified 54% (N = 145) of their population (N = 297) as suffering from schizophrenia/affective disorders, 16% as having neurotic disorders, 16% as having personality disorders, 7% as having alcohol/drug abuse related problems, and 4% with accidental brain damage.

The Vocational Services Sub-Committee reported that 91% of their population served were under 40 years of age (51% were under 30 years of age).

In this sample of clients, 76% lived on their own, with family, or in a rooming house; 6% reported living in a boarding house (not clear if this was licensed or not); and 12% identified a Home for Special Care (institution or group home) as their residence. 6% were in various other residential settings.

Eighty-eight percent of their mentally disabled participants in these programs reported Grade 12 or less as their upper formal education achievement.

Sixty percent of these people reported Municipal Assistance or Family Benefits as their income source; 12% reported it to be U.I.C., 12% reported it to be family support; the balance of 16% reported U.I.C., other employment earnings, and own resources as their primary income source.

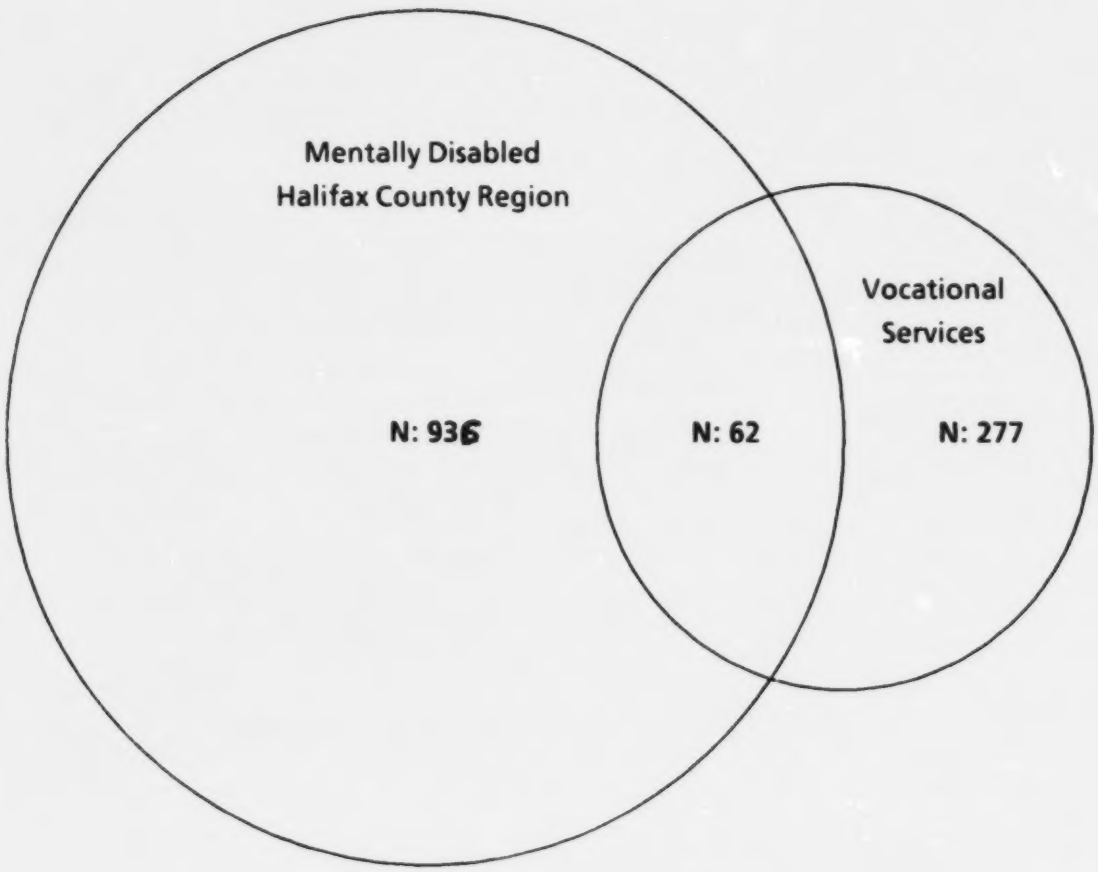
FIGURE 12:
Overview of data obtained by Vocational Services Sub - Committee

PROGRAM DATA ITEM	1 *	2	3	4	5	TOTAL
MALE	26	72	29	22	22	171
FEMALE	12	58	7	6	14	97
TOTAL	38	130	36	28	36	268
NO 40 + YEARS OLD	1	12	1	13	2	29
NO. GRADE 12 OR LESS	100%	85%	76%	96%	100%	–
RESIDENCE TYPE						
OWN HOME	16%	52%	8%	14%	0%	
WITH FAMILY	29%	21%	22%	21%	31%	
HOME FOR SPECIAL CARE	25%	11%	25%	43%	8%	
ROOM	24%	12%	22%	14%	61%	
OTHER	6%	4%	22%	7%	0%	
INCOME TYPE						
M.S.A.	42%	20%	28%	29%	42%	
F.B.	26%	28%	50%	39%	31%	
U.I.C.	11%	23%	14%	10.5%	8%	
EMPLOYMENT	8%	9%	–	–	–	
OTHER	14%	20%	8%	22%	19%	
DIAGNOSIS						
SCHIZOPHRENIA/AFFECTIVE	55%	60%	64%	39%	33%	
NEUROTIC	8%	25%	14%	–	11%	
PERSONALITY DISORDER	26%	8%	19%	29%	33%	
DRUG/ALCOHOL ABUSE	8%	2%	3%	21%	19%	
BRAIN DAMAGE(accident)	3%	5%	–	11%	3%	

* Numbers refer to the following

1. Dartmouth Work Activity
2. Employment Outreach Counselling
3. Haltrans
4. Lake City Industries
5. Options

Figure 13:
The following diagram graphically illustrates the vocational services to the mentally disabled.



The mentally disabled population identified by the Officials Committee is 936 using the definition in the preceding chapters. The 277 people are those that are serviced by the representation on the Vocational Services Sub-Committee; 145 of the 277 suffer from schizophrenia/affective disorders. The 62 persons are the proportion of the needs assessment sample who reported a current or previous involvement with the agencies represented on the Vocational Services Sub-Committee.

D. **Nutrition & Hygiene**

1. More individuals in supervised settings feel positively about their eating habits and would like to learn more about nutrition.
2. More people in supervised residences would also like assistance with cooking and with shopping than those in self-care situations.
3. In comparison to other settings a higher percentage of people in self-care circumstances feel no need for help with hygiene.

E. **Medical/Psychiatric**

1. More of those in supervised settings reported receiving counselling on a regular basis during the past year compared with the rates reported in the other two sub- groups; i.e., 81% reported in the supervised residence group; 51% in the self-care group and 32% in the licensed facility group.
2. More of those in supervised settings felt positively about their emotional well being (76%) than those in self-care (58%) or in licensed facilities (38%).
3. Approximately 50% of residents in all settings felt positive about their health. The rate was slightly higher for persons in supervised residences (60%).
4. People in supervised settings reported a higher rate of regular contact with their physicians. Those in self- care reported the lowest rate of contact.
5. People in supervised settings reported experiencing mental illness at a younger average age and were hospitalized at a younger age.
6. For all sub-groups, most persons reported hospitalization of less than 9 months for first stay but those in supervised settings proportionately reported longer stays of 2 to 5 years and proportionately were more likely to have had more than 3 admissions to hospitals.
7. Those in self-care circumstances were proportionately the least likely to have been hospitalized during the past five years.
8. A higher proportion of those in self-care circumstances reported not using psychiatric services during the past year.
9. In all three settings the majority reported that their psychiatrist or family doctor was the most helpful service available to them.
10. After reviewing a list of available services, a very high proportion of those sampled in self-care circumstances (36%) felt that no services were helpful, while only 4% of those in supervised residences felt this way.
11. Proportionately, those in self-care circumstances appear to be the least likely to be taking medication for mental problems; i.e., 89% of those in licensed facilities, 85% in supervised residences and 66% in self- care are taking medications.

F. **General Satisfaction**

In the Supervised Community Living Group two thirds reported feeling "pretty happy" or "very happy" about their life thus far. This was the case with only slightly more than one half the Licensed Facility Group.

Almost all in the Supervised community Living Group reported they wished to make none or only a few changes to their life. The promotion of those in Self Care with a similar view was almost three quarters and slightly over half in the Licensed Facility Group.

The Supervised Community Living Group most frequently reported their lives as very or fairly stressful. The Licensed Facility Group reported least frequently their life as being very or fairly stressful.

It is interesting to note that although the Supervised Community Living Group reported more frequently their life as stressful, they also had the highest frequency of not wanting to change their life; as well, they had the highest frequency of feeling positive to their life thus far. The converse is almost true for the Licensed Facility Group.

Those in supervised settings appear to have the most positive outlook on life (i.e., 65% in supervised residences, 57% in self-care, and 44% in licensed facilities). Those in supervised settings would also appear to want to make the least number of changes in their current life style (i.e., 92% in supervised residences, 72% in self-care and 56% in licensed facilities). Proportionally, however, people in supervised residences report the highest degree of feelings of stress in their lives (69% in supervised residences, 64% in self-care and 44% in licensed facilities).

G. SUMMARY OF FINDINGS

- [] The mentally disabled can be found in all three types of settings.
- [] Within any one setting clients have widely differing characteristics - age, sex, previous clinical history, social history, needs and satisfactions.
- [] Within any specific setting there are people with quite different behaviors, problems, and needs. The client populations are heterogeneous.
- [] Some clients are at inappropriate levels of care, one half of residents in licensed facilities are appropriate for levels of care with less supervision, while one quarter require care levels with more staff attention (Section 7). Client programs and placements need frequent review for more appropriate programming and better utilization of scarce resources. As space availability may be a significant determinant in placement in settings, and as needs change over time, reassessment of setting appropriateness and flexible transfer systems are obvious. A wide range of flexible programs and placements are needed. Modifications to existing programs or development of programs is needed to meet current client needs.
- [] The nature and quality of staff are, at least, as significant as the number of staff hours per client.
- [] Most clients expressed needs for social support, social stimulation and social opportunities. They want improved opportunities for work, recreation, and better housing.
- [] Care givers recognize their clients' need for more independent care.
- [] The current needs of most institutionalized clients can be met at care levels providing more independence.
- [] The Level of Care Instrument could provide a basis for longer term goal setting, care/treatment planning, and the monitoring of the fit between placement and care level need.

7. LEVEL OF CARE SURVEY

This questionnaire was designed in 1975 by the Office of Mental Health, Bureau of Program Evaluation, New York. The purpose is to measure habits, behaviours, and symptoms which influence the type of care required: vision, hearing, speech, comprehension, physical health, nursing care, mental health, psychiatric management, and activities of daily living. This questionnaire was administered by the nursing and supervisory staff in licensed facilities and municipal/provincial social assistance workers.

The survey instrument determining an estimate of the most appropriate care setting for the client. It has been applied in psychiatric programs in British Columbia, New Brunswick, Nova Scotia, Ontario and Quebec. It uses detailed information about the client's recent objective behaviours to classify the client into the following levels of care:

Independent/self-care;
Supervised settings;
Rehabilitation settings; and
Psychiatric settings.

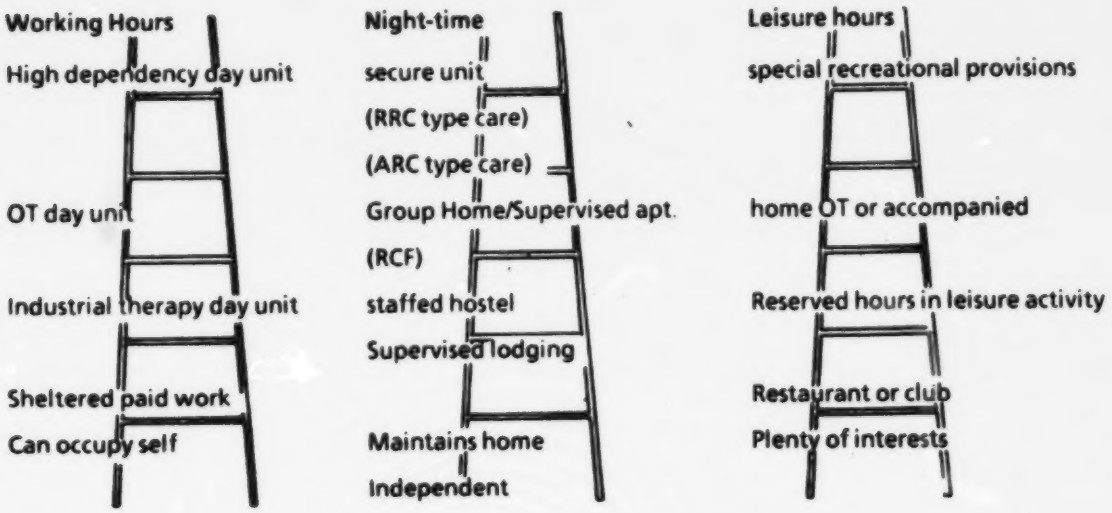
Mentally disabled persons have many needs. Some cases can live independently in the community, some can live in protective living environments, some require a structured rehabilitative environment.

We can consider three sectors of care:

- programs during working hours
- programs during night-time and
- programs for leisure.

These three sectors can be arranged in three "ladders". The ladders show the spectrum of programs which are needed for community clients. This concept is illustrated in the next diagram (from John Wing).

FIGURE 14:
Stairways and resting places *



* Wing, J
The cycle of Planning and Evaluation in Provision of Mental Health Services in Britain
(in Wilkinson & Freeman)

Some cases require a high level of care (more staffing and supervision) for one of these ladders and low levels of care (less staffing and little supervision) for the other two. Some cases require high levels of care for all three ladders, some require low levels of care for all three ladders. Some cases will move from level to level; others will attain and stay at a particular level for some time. We need a range of flexible programs which can meet the particular needs of individuals.

The Level of Care Survey in 1987 was completed for 201 clients by personal care workers in licensed facilities and by social workers for clients in self-care or supervised settings.

Findings

1. Of 201 cases surveyed, 100 were in licensed facilities, 11 in community residences and supervised residence program, and 90 persons were living independently with either FB or MSA income support.

2. Among the 100 clients sampled in licensed facilities, 47% were considered appropriate for more independent settings; 27% for community programs with same degree of supervision; 9% for a rehabilitative type of setting; and 17% for a higher level of care; i.e. 9% were at the appropriate level of care; 74% require lesser levels of service and 17% higher levels of care.

3. In the self-care settings, (N = 90), 70% were in appropriate settings and 30% were classified as needing more care.

4. Of those (N = 11) in the supervised program 64% were thought to need less care and 9% more, with 27% considered appropriately placed.

5. In 81 cases, the Personal Care Worker or social worker also estimated the level of care for their particular clients: 56% thought their clients were at the appropriate levels of care; 32% thought their clients needed higher levels of care, 12% thought a lesser level of care was appropriate.

6. The most striking finding is the inappropriate levels of care. Some of the clients have changed since admission and now have different needs; others were originally placed because of the lack of more suitable settings.

Figure 15, on the next page shows the extrapolation of the findings from the Level of Care Survey to the total number of 936 clients. The following changes would occur:

	Actual Setting (Summer 1987)	Appropriate setting
Independent	687	617
Supervised	132	242
Rehabilitation	117	77
Total	**936**	**936**

Extrapolation of Level of Care Survey results

	Service Settings in 1987	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
			Results of extrapolation						
			Independent	Supervised			Rehabilitation		
				RCF type	ARC	Ext care	Grp home	RRC	RRC + 24hr
				Comm Res type	type	unit	Sup apt	type	nursing
A	Independent (family or self)	687	496	61	84	0	46	0	0
	Supervised								
B	*RCF*	79	29	31	10	1	6	0	1
C	*Community residence*	32	21	0	0	0	11	0	0
D	*ARC*	21	0	17	0	0	3	1	0
E	*Ext care unit*	0	0	0	0	0	0	0	0
	Rehabilitation								
F	*Group home*	18	14	2	0	0	2	0	0
G	*Supervised apt*	79	49	10	10	10			
H	*RRC*	20	7	6			1	5	1
I	*RRC + 24 hr nursing*	0	0	0	0	0	0	0	0
J	TOTAL	936	617	127	104	11	69	6	2

Figure 15:

8. OBSERVATIONS AND CONCLUSIONS

A. The mentally disabled population

(i) The task of enumerating the mentally disabled in the Halifax County region is feasible. It is possible to count the number of persons in this region who are in receipt of provincial and/or municipal assistance and have a functional psychosis (schizophrenia or affective disorders) which has disabled the person for over one year.

(ii) There are about 1000 persons in the Halifax County region who have long-term mental disability, are under 65 years of age and receive provincial and/or municipal assistance. There is an additional number of people who are mentally disabled, who do not use the social assistance income support, who are in receipt of Canada Pension (or other insurance) or are supported by family. This number is estimated at 500. Although this latter group was not targeted in the survey, it is most likely that their needs are not greater than the needs of the sample.

(iii) Most "homeless" people have not been long term mental hospital patients. (American Journal of Public Health, 76:519- 524, 1986) Some, but not all homeless people are mentally disabled.

B. Facts

The dehospitalization process will likely continue. The number and rate of new long-stay hospital patients has decreased over the past ten years. The rate for long stay hospital patients for Nova Scotia and the Halifax County Region is now similar to Ontario's. The emphasis on community care for the mentally disabled will continue and likely increase.

- [] The gradual reduction in the numbers of long stay persons in psychiatric hospitals has seen a corresponding increase in the people on social assistance.
- [] The numbers of Halifax region mentally disabled in various social service institutions has decreased over the last ten years and is likely to continue decreasing.
- [] The majority of mentally disabled people live with families or in private lodgings.
- [] Mentally disabled people tend to remain stable with regard to their residency.
- [] The majority of those with a mental disability in the community do not have major, persistent psychiatric and social crises. The majority continue to function at some level of adaptation that is more or less "adequate" with few social crises.
- [] Two thirds of the mentally disabled are relatively satisfied with their circumstances. One third are, to some extent, dissatisfied. Although this group is largely satisfied with their social situation, they do recognize one or more areas in which they need help.
- [] Higher cost and more intensely staffed settings do not necessarily have more residents who are satisfied.
- [] There are a variety of identifiable barriers to vocational training and/or employment.
- [] Supports from family or significant others are crucial factors in predicting success in vocational training and/or employment.
- [] Low educational levels and the complexity of labor market coupled with mental disability conspire to present real barriers to employment.
- [] Paucity of discharge planning information and the lack of any kind of a centralized or coordinated assessment service usually means that many of the vocational service providers must discover through observation the full nature of a client's particular presenting features before a remedial strategy can be developed and directed toward the problem(s).

9. STRATEGIES FOR THE NEW SYSTEM

The service settings

Currently, there are three major types of service settings each with their own historical/philosophical base.

- The institutional services (Adult Residential Centers, Regional Rehabilitation Centers, to some extent Residential Care Facilities) owe their origins to the "asylum" approach to care for the mentally disabled.
- Group Homes had a similar philosophical origin but combined this with the developmental model promoted by the Associations for the Mentally Handicapped .
- The self care setting which frequently involves family care-giving has its origins in the belief of mental disability as a medical issue (rather than social deviance) and has been facilitated by the income maintenance programs. The third group is a model combining elements of the first two whereby some structure is provided and care is rendered by staff who substitute, in a sense, for family.

Desirable Features of Services

A service system needs to be perceived of as a continuum of service based on a comprehensive assessment of the person's needs. Entry to a specific service needs to be "client need determined" and not always require a new assessment from the direct service provider.

The assessment phase and reporting on the functioning and potential of a program participant needs to be integrated with other service providers specifically those providing counselling, psychiatric care, housing, etc.

Following is an outline of the key ingredients of a service system for mentally disabled persons.

i Longitudinal - long term planning for the development of clients employment potential is a priority.

ii Individual - the plan is developed with and for the client so that it is specific to their needs.

iii Comprehensive - a range of service components are put in place to meet a variety of social, vocational, recreational needs. The full scope of employment options should range from full-time, competitive, to part-time or share work, to transitional to avocational options.

iv Flexibility - refers to ease of movement within the range of options.

v Relationship - means the client should be able to rely over time on having associations with a person or persons who are interested in him/her.

vi Accessibility - means the client can reach the system in a way that is manageable both psychologically and financially.

vii Communication - between the client and the service providers, and among service providers is the link which ties all the preceding qualities together.

An ideal service should also be culturally relevant and accountable.

- [] Each client has an individual service plan.
- [] There is a regular and frequent review of the service plan.
- [] There is a designated person for each client. This designated person may come from various disciplines or settings. The designated person is responsible for coordination, continuity and communication.

- [] There is continuing review of the needs of each client and the extent to which they are being met. This review is done on a case-by-case basis.
- [] Clients with functional psychoses have priority in this program.
- [] There is a continuing need for overview of the program involving input from and feedback to all components of the service system. Case-by-case data need to be collected in order to have a comprehensive view of the services and client population.

The review of the various data collected, reports from community groups, and the observation of professionals in the service delivery system identifies differing target groups of dysfunctional people, with common and differing needs but usually with differing means required to meet those needs.

The preceding information in both the "Findings" section and the "Conclusions" section of this report shows a high degree of inappropriate levels of service because either clients change over time or because at initial contact the choices were so limited that "something was better than nothing".

10. SERVICE DELIVERY CHOICES

The future of services to the mentally disabled can proceed in one of the following three ways.

Option One: Expansion of Existing Services

Increase the number of beds available in RRC, ARC, RCF's, Supervised Apartments, Community Residences, and vocational (workshop) placements. Expand the present system so that there is a surplus of accommodation available and continue to maintain this surplus. Even though there is an ever increasing supply, demand will quickly follow and fill the available supply. Because of the catch up, at best this is a stop-gap or interim solution.

Option Two: The Multi-Service Co-ordination Model

This model brings together a range of services provided by specialists in an isolated (separate from general community services) and fragmented manner (there are no built in assurances that one service knows what another is doing even when the services are housed together). This one stop multi-service encourages co-ordination of services from the service providers perspective but has historically resulted in limited integration on the administrative, policy, and planning levels.

Develop a segregated service system for the mentally disabled population which will provide a "one-stop" service centre approach to this (mentally disabled) segment of the population. This service centre is within the community but culturally, socially, recreationally, vocationally, etc.remote. In other words, its view is inward as opposed to the outward-integrating and client developmental orientation.

Option Three: Accessible Integrated Option

i Help the mentally disabled to meet their needs by use of existing services and provide ongoing support.

ii Increase the number of community workers.

iii Develop a system of services which respond to the priorities of the mentally disabled.

- [] Recognize the needs of the clients. The needs of the clients would "drive the system."
- [] Develop service plans for individual cases in collaboration with other members of the community service network. Revise these service plans regularly.
- [] Integrate with existing resources. Provide appropriate levels of support and accessible services.

[] Help create new options to meet the need only if existing generic services can not adjust to the needs of the mentally disabled.

Within this third option there should be a network of service, support and back-up. One person would be the designated person for a specific client; the designated person would serve as the chairperson for continuing coordination among the service network, communicate service (generic or specialized) and client changes, and update the service plan.

The first phase of the execution of option three is to concentrate on providing appropriate services to those in inappropriate levels of care.

We choose the third alternative.

11. RECOMMENDATIONS

Preamble

Generally speaking there is a substantial number of mentally disabled persons in the Metro area who are not in appropriate levels of care (Level of Care Study (1987). There are mentally disabled persons both inside the Home for Special Care system, as well as outside, who require, or would benefit from, different kinds of care/services than they are currently receiving.

Although the existing system makes every effort to provide residential services appropriate to the needs of the client group, extraneous factors, e.g. discharge procedures, available beds, and limitations on non-residential support services, leads to a facility/program driven system as opposed to a client/needs driven system.

In order to address the situation described above, it is recommended that the following steps be taken, relative to the specific recommendations below:

1. That the mentally disabled population be recognized as requiring a continuum of programs/services to meet their diverse needs.
2. A case-by-case needs assessment will be carried out on all clients in licensed settings.
3. The development of a metro-wide overall plan for the progressive transition of some smaller licensed and unlicensed community residential options to more intensive programming and rehabilitative levels of care (i.e. ARC-RRC levels).
4. The gradual movement of clients, over a 3 to 7 year period, to levels of care deemed more appropriate for their individual needs. (Considerable care would need to be given to reducing unnecessary disruption to current clients during this phase-in period.)
5. Initially the movement would be towards lesser levels of care in appropriately staffed facilities. Eventually more of the clients would be involved in community support programs within community living situations.

N.B. In the following recommendations, reference to "RRC" "ARC", "RCF", "Group Home", "Community Residence", "Supervised Apartment" and "Independent Living" refer to a level of care and not to any specific facility. Further, certain groupings of level of care were seen as closely related -- Residential Care Facility and Community Residence are considered similar as are Group Home and Supervised Apartment.

Recommendation #1

Since a substantial number of individuals (with settlement in Metro municipalities) in the Halifax Co. RRC require lesser levels of care, it is recommended that after individual assessment, they be gradually moved to the appropriate level of care (see Figure 15).

Recommendation #II

A. In view of findings of the Level of Care Survey and because of the relatively low level of current demand for RRC level of care (General Services) from the Metro area, it is recommended that community residential programs be designated, either through the conversion of existing group home or RCF programs, to provide a level of care and rehabilitation program equivalent to RRC. Further, in order to concentrate financial resources in this area, it is recommended that the RRC level of care (General Service Units) at existing facilities be phased out.

B. Consistent with the movement to community based smaller facilities, it is recommended that one or more RCF facilities be upgraded to provide services equivalent to current ARC levels of care.

C. In addition to "A" and "B: above, it is recommended that unlicensed options (supervised apartments, community residences) be encouraged to provide care/program levels equivalent to both current RRC and ARC levels, enabling new clients requiring this level of care to be served in the community.

Recommendation #III

The Homes for Special Care Task Force of 1985 recommended that the Residential Care Facility System be reviewed so that individual homes would focus on the needs of the aged or the younger mentally disabled, but not both. It is recommended that this course of action be actively pursued in the Metro area.

Recommendation #IV

In light of the findings in the Level of Care Survey and in order to ensure appropriate placements, it is recommended that a number (possible 10) assessment/crisis beds be developed in the metro region. Preferably, these beds should be dispersed throughout the Metro Region. designating one bed per Residential Care Facility or utilizing a "small option model for this purpose.

Recommendation #V

When specific RCF's are designated to provide assessment/crisis beds, it is recommended that staff be provided with training programs to assist them in effectively participating in the needs assessment process.

Recommendation #VI

It is recommended that a program of providing community support workers to appropriate mentally disabled clients in unlicensed settings and in independent living situations be implemented (See Figure 17)

Recommendation #VII

Vocational and prevocational services should be pluralistic and meet a spectrum of needs of the individuals. The spectrum's range needs to be from "Project 50" to "supportive work placement counselling".

A. This spectrum needs to be viewed as a system to provide the person with progression and/or maintenance at a level in keeping with the needs of the person. The mentally disabled population is fluid in that people's mental health status changes from more to less acute and vice versa.

B. It is recommended that, whenever feasible, generic services should be utilized for employment and training purposes for mentally disabled persons.

C. "Project 50" needs to be more broadly available especially for those not in receipt of Municipal Assistance and Family Benefits in order to provide mentally disabled persons with incentives and opportunities for purposeful activity in keeping with their abilities.

D. Specialized employment counselling services need to be incorporated into the generic services of employment support centres in light of such centres' access to employability support programs and job opportunities.

E. Supported work programs should be expanded both in Halifax and Dartmouth to ease the transition to the work force and increase the options of mentally disabled persons.

F. The feasibility of lengthening the training period and broadening the services available to mentally disabled persons within Work Activity Projects needs to be explored. Cost sharing considerations should be addressed during this review process.

G. It is strongly recommended that the "designated workers", referenced in Figure I6, play a central role in brokering vocational, training and employment related services for mentally disabled persons and that these services be provided in a manner consistent with principles of holistic and individualized program planning and case management strategies.

Recommendation #VIII

It is recommended that further attention be directed to additional sub-groups of the mentally disabled.

These sub-groups would include: *

- younger mentally disabled who have not had prolonged histories of institutionalization or who have not been involved in residential or day programs;
- persons with mental disability (as defined earlier) who also have concurrent major problems with alcoholism and drug abuse;
- persons with dual diagnoses of mental handicap and mental disability;
- persons with major evidence of specific brain damage in addition to the mental disability;
- persons with severe personality disorders in addition to their mental disability.

These groups all require further study and needs assessments.

* See Section 3

Recommendation #IX

It is recommended that family support, respite and counselling services be provided/developed, where applicable, to assist families maintaining mentally disabled individuals in the family home.

Recommendation #X

It is recommended that consumer and self-help groups be encouraged and developed to respond where possible to the needs of the mentally disabled and to participate fully in service planning and development.

Recommendation #XI

It is recommended that a metro-wide implementation committee be established with the responsibility to ensure the implementation of approved recommendations and to develop and maintain a system to update data on the overall population of the mentally disabled, service utilization, service needs so as to ensure that programs respond to changing needs. This committee should be mandated by and report at least annually to the Minister, Mayors and Warden as to the status of implementation.

Recommendation #XII

It is recommended that Municipal Social Services Departments, designated as the prime source for community programs, be assured sufficient funding to carry out their mandate.

Recommendation XIII

It is recommended that any Implementation Committee established under the auspices of Provincial and Municipal Community Services Departments discuss with the Department of Health & Fitness and the relevant hospitals the current practices in order to promote comprehensive services and continuity of care for the mentally disabled outside as well as inside of the hospital system.

Figure 16:

Suggested role and functions of assessment/crisis beds

The assessment/crisis beds would serve two functions:

(i) For some persons being discharged from a psychiatric in patient hospital they, on a voluntary basis, would be assigned to a crisis/assessment bed for a maximum period of 21 days during which a long term case plan would be developed assessing support needs, vocational and avocational needs, and other relevant factors.

(ii) This provides a better system for assessing the needs and abilities of clients entering the system in a community based program rather than from interview with the clients only in hospital and from documents.

The room, board, and general supervision would be provided by existing facility staff.

Each hospital would assign one of their social workers who would be the liaison between the hospital and the assessment/crisis program, to channel referrals to the appropriate unit, to provide relevant information, to participate in the assessment and to facilitate in general the assessment process.

The mentally disabled person would be assigned a "designated worker" and an average of four hours per week of occupational therapy services. Also there would be time designated from a community support worker.

The designated worker would come from the Municipal Community Care staff funded by the Department of Community Services by funds generated from the decreased use of R.R.C. beds.

A designated worker would be able to be responsible for all clients in the assessment/crisis beds, assist in the arrangement of longer term residential, day, and other programs for the person.

Occupational therapy/vocational services would assess and assist the person in securing appropriate vocational and/or avocational services.

The community support worker would provide help with activities of daily living and a generalized supportive role.

Referrals to Classification committee during 1987 from psychiatric hospitals (Nova Scotia Hospital and Abbie Lane Hospital) were estimated at about 100 individuals. The assessment of hospital discharges is estimated to require a maximum of 2700 bed days of a total of 3650 bed days available. The balance of bed days (950 bed days) would be utilized by persons in social service residential programs requiring short term crisis intervention and re-assessment.

Payment for the assessment/crisis program would be managed by using a lower occupancy rate in calculating the per diem rate of the specific facility used for this service.

Figure 17:
Role and function of community support workers

The function of the community support workers would be to:

(i) provide a generalized supportive relationship to the mentally disabled in the community

(ii) provide help with activities of daily living such as housekeeping budgeting, shopping, etc.

(iii) help the person connect with community resources

(iv) liaise with the other people involved, share appropriate information on the person's current functioning

(v) provide some relief and release to families who are caring for a mentally disabled person

(vi) help mentally disabled persons access generic recreation, vocational, residential, etc. services

Generic social and recreational services should be utilized as a general rule for mentally disabled persons supplementing these services with specialized programs based on individual needs.

The Level of Care survey results estimated that there were 319 persons needing ARC or RRC type levels of care. Currently community support workers are working with 79 clients in supervised apartments. Thus there would be 319-79 = 240 clients in licensed or supervised settings who would be the initial target group for community support workers.

12. FINANCIAL CONSIDERATIONS

It is difficult to estimate all of the direct and indirect cost implications of the recommendations outlined in this paper and much more detailed planning will be required by a planning and implementation committee.

The Officials Committee, therefore, presents only some general considerations and an approximate costing of "Year I" of the implementation process.

A. General Considerations

1) As with any changing system, there is always a short term period of "double cost", i.e. when most of the costs in the existing system continue while the new system is being put into place.

2) Manpower in Municipal Social Services Departments is currently stretched to the limits to service the current system. In order to effectively address the recommendations, initial new resources should be devoted to strengthening the individual and regional Municipal Social Services system to effectively address the recommendations in a quality and co-ordinated manner.

3) In the longer term, the recommendations assume that the metro area municipalities will no longer require Adult Residential Centres (ARC) or general service units in Regional Rehabilitation Centres (RRC) for the mentally disabled and that these current expenses will offset additional community service costs when and if they can be fully transferred to community social service ventures. (See Annex I)

B. Year #1 - Implementation Process

Based on the general considerations, it is recommended that the following objectives be pursued in Year I of the implementation process:

1) Develop individual program plans for 15 individuals (as of June 1989) in the Halifax Co. RRC and arrange for their movement to community service options effectively utilizing existing support services.

City of Halifax	-	5 persons
City of Dartmouth	-	6 persons
County of Halifax and Bedford	-	4 persons
TOTAL	-	**15 persons**

(It is assumed from assessments that these individuals will require group home level* residential services.)

2) Develop individual program plans for 7 individuals from the Adult Residential Centre system and arrange for their movement to community services options effectively utilizing existing support services.

City of Halifax	-	3 persons
City of Dartmouth	-	1 persons
County of Halifax	-	2 persons
Town of Bedford	-	1 persons
TOTAL	-	**7 persons**

(It is assumed from assessments that these individuals will require group home level* services.)

*Group Home Level does not necessarily imply traditional eight-bed group homes, but rather a program/care level and is used here in order to estimate approximate cost projections.

3) Provide additional resources to the Vocational/Day Program service system to accommodate the 22 persons noted in 1) and 2) above leaving the institutional system. Some of these individuals may fit into the existing service system, while others will require new services. In order to develop cost projections for Year #1, an average additional cost of $6,500.00 per client is used.

4) Develop an individual and metro wide Municipal Social Services capability to:

a. Effectively plan for and place the 22 individuals identified for Year 1.

b. Update functional and need assessments on the General Assistance caseloads of mentally disabled clients in each municipality to determine needs for specific additional support requirements.

c. Transfer a total of 90 clients (metro wide) from General Assistance caseloads to Community Care caseloads through the addition of three "designated workers" and three community support workers.

d. Provide manpower to the Implementation Committee to implement the recommendations in a three year period.

e. Formalize relationships among MMHPB, Hospitals, Mental Health Clinics, and other organizations providing services to the mentally disabled.

5) It is suggested that in order to effectively address the above, that each of the three Municipal Social Service Departments will require:

a. An additional worker (designated worker) in each Community Care Division whose primary tasks relate to:

i) planning for the institutional population identified in year #1;

ii) reviewing in depth the needs of the existing mentally disabled General Assistance population; and finally,

iii) developing an on-going relationship with 20 to 30 clients currently receiving only General Assistance services and provide and promote access to comprehensive community support services.

b) An additional Community Support Worker in each Community Care division to carry out the duties as described in Figure 17.

c) A Community Development Worker assigned by the Municipal Social Services Department to:

- work with all Municipal Social Services staff within the Unit;
- identify support services needs of mentally disabled clients on overall municipal basis;
- work with counterparts in other metro municipal units as a team to collectively "staff" the Implementation Committee process and ensure the orderly development of specialized community services and the integration of the mentally disabled into generic community services.

(Community Development Workers are projected to be required on a 3 year term basis with positions either terminated or converted to designated worker roles after this period.)

C. Estimated costs - Year #1

1) Twenty-two (22) additional community residential placements at approximately $18,000.00 per residential placement in provincial/municipal costs:

22 x $18,000 = $396,000.00

2) Twenty-two (22) additional Vocational Day Program placements at approximately $6,500.00 per placement in provincial costs:

22 x $6,500.00 = $143,000.00

3) Three (3) additional "designated workers", plus three (3) additional Community Support Workers, plus three (3) additional Community Developments Workers, for a total of 9 staff at approximate costs of $35,000.00 per position (support costs included):

9 x $35,000.00 = $270,000.00

Total estimated costs - Year #1

1. Residential costs	=	$396,000.00
2. Vocational Program costs	=	$143,000.00
3. Staff Service Costs	=	$270,000.00
Total cost estimates	=	**$809,000.00**

13. ACKNOWLEDGEMENTS

A. OFFICIALS COMMITTEE MEMBERS

Mr. James A. MacIsaac, Chairperson
Ms. Carol Bethune, Town of Bedford
Mr. Bob Britton, City of Halifax
Mr. Tom Cleary, City of Dartmouth
Ms. Pat Conrad, City of Halifax
Mr. Harold Crowell, City of Halifax
Mr. Paul Greene, City of Dartmouth
Mr. Ron L'Esperence, NS Department of Community Services
Mr. Ed Mason, County of Halifax
Ms. Joan Pryde, Town of Bedford
Dr. Alex Richman, Consultant
Ms. Ada Smith, County of Halifax
Mr. Ross Thorpe, NS Department of Community Services

B. DATA COLLECTION SUB-COMMITTEE

Mr. Bob Britton, Chairperson
Ms. Carol Bethune
Mr. Tom Cleary
Ms. Pat Conrad
Dr. Alex Richman
Ms. Ada Smith
Mr. Ross Thorpe

C. VOCATIONAL SERVICES SUB-COMMITTEE

Mr. Ron L'Esperance, Chairperson
Ms. Janet Bews, Haltrans Industries
Mr. Ron Calder, Mental Health Outreach
Mr. Doug Crossman, C.M.H.A.
Mr. Chris Fyles, Lake City Industries
Mr. Frank Gibson, Dartmouth Work Activity Program
Ms. Norma Lloyd, Department of Community Services
Mr. Jamie MacDonald, Haltrans Industries
Ms. Doreen Parsons, Options Work Activity Project

D. The Committee acknowledges the funding provided by the Department of Community Services, the City of Dartmouth, the Town of Bedford, the County of Halifax, and the City of Halifax to provide three term staff, Catherine Verkuyl, Joanne Walker, and Louise Arsenault.

The Committee acknowledges the computer services provided by Ms. Kathleen Fogarty of the City of Halifax, the computer time provided by the City of Halifax, the assistance of the Family Benefits division of the Dept. of Community Services and the participation by staff workers in licensed facilities and residential facilities for the mentally disabled.

The Committee acknowledges the support services provided by Susan Neklia, Geri Crosato, Jocelyn LeClerc, Jenni Whitten, Norene Reinhardt,Diane Smith and Darlene Yates.

E. Most of all the Committee acknowledges the participation, openness and warm welcome the clients extended to the survey team.

ANNEX I

Current RRC Placement Costs vs Estimated Costs If Level of Care Findings Applied

1. **Current RRC Cost Estimates**

In the Level of Care Survey (1987) there were 20 residents at the Halifax County RRC who were mentally disabled and had settlement in Halifax County, Bedford, Dartmouth or Halifax City.

The cost of maintaining these residents is estimated at $129.52 per day (1988 approved rate). The gross cost for a full year is therefore estimated at $945,496.00 for the 20 residents in question.

The Level of Care Survey determined that 14 of the 20 required a lower level of care. The current cost to maintain these 14 persons for one full year at the higher level than required is $675,490.00.

2. **Level of Care Comparisons for 14 RRC Clients**

It is estimated that if, for instance, these 14 persons alone could be placed according to the findings of the Level of Care Survey, then appropriate costs would be as follows:

A. **Residential Costs** *

"Independent" Living - 7 clients at $20.98/diem	=	$ 53,603.00/yr
"RCF Type Level" - 6 clients at $28.99/diem	=	$ 63,488.00/yr
"Group Home Level" - 1 client at $53.88/diem	=	$ 19,666.00/yr
Total Residential Costs for 14 clients	=	**$136,758.00/yr**

*Per Diem costs based on average costs for City of Halifax clients at various levels of care in 1988 dollars.

B. **Vocational Day Program Service Costs**

While it is difficult to determine precisely what programs these individual clients would require, it is anticipated they would vary from relatively low cost Project 50 type involvements to more costly workshop/work placement type placements. For averaging purposes an amount of $6,500.00/client is projected.

Thus:	14 x $6,500.00	=	$ 91,000.00
	Total Day Program Costs	=	**$ 91,000.00**

C. **Designated Worker & Community Support Worker Costs**

As these individuals would be living in more independent circumstances, they will require the services of specialized municipal support staff.

(1) A "designated worker", usually a staff person with the Municipal Social Services, Community Care Department would be required to provide overall care management services for the individual. A formula of one (1) worker per 30 clients is used to determine approximate per client costs, i.e.

1 worker for 30 clients	=	$ 35,000.00
1/2 worker for 14 clients	=	$ 17,000.00

Thus approximate cost for designated worker costs for the 14 RRC clients = $ 17,000.00

(2) A community "support worker" would be required for those individuals who were returning to "independent living or "supervised apartment" type of settings. It is estimated that a community support worker could provide service to approximately 20 clients per month (assuming varying degrees of intensity) at a cost of approximately $35,000/worker.

Thus for the purpose of the Level of Care Comparisons for the 14 individuals in question,

(a) 6 clients living "independently"

(b) 6 clients represent 30% of average case load for one "community support worker" (Allowing for higher intensity of demand by RRC graduate would make up 50% of "community support worker" caseload.)

(c) Thus approximate costs for "community support worker" for 6 of the 14 clients is: 50% $35,000 = $ 17,500.00

Total "Designated Worker" Plus Community Support workers equals:

$17,000.00 + $17,500.00 = $ 34,500.00

COST SUMMARY

Total RRC costs for 14 clients deemed to require lesser Levels of Care = $675,490.00

Total costs for 14 clients in appropriate Levels of Care:

A.	Residential	=	$136,758.00
B.	Voc/Day Program Costs	=	91,000.00
C.	Staff Support Costs	=	34,500.00
	TOTAL COSTS	=	**$262,258.00**